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IN THE

# Supreme Court of the United States

**October Term, 1984**

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SEBASTIAN REBALDO, as Chairperson of the Board of the Trustees of the UNITED OPTICAL WORKERS FUND,

*Petitioner,*

*against*

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

*Respondents.*

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**On Petition for a writ of Certiorari to the United States Court of Appeals for the Second Circuit**

## BRIEF IN OPPOSITION

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38 pp

## Question Presented

Is an experimental New York statute that regulates the price of all hospital inpatient charges preempted by § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a), when the charges are paid by ERISA-covered, self-insured employee welfare plans?

# TABLE OF CONTENTS


| | PAGE |
|---|---|
| Statement of the Case | 1 |
| A. New York's Prospective Hospital Reimbursement Methodology | 1 |
| B. The United Optical Workers' ERISA-Covered Employee Welfare Plan | 10 |
| C. Proceedings In The District Court And The Opinion Below | 12 |
| The Writ Should Be Denied | 17 |
| The Decision Below Is Correct Because ERISA-Covered Employee Welfare Plans And NYPHRM's Equal Charges Requirement Cannot Relate To Each Other Under ERISA § 514(a). There Is No Conflict With Decisions Of This Court Or With Decisions From The Circuits On This Point | 17 |
| Conclusion | 30 |

## TABLE OF AUTHORITIES

*Cases:* PAGE

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) ..... *passim*

American Progressive Life Insurance Co. v. Corcoran, 715 F.2d 784 (2d Cir. 1983) ..... 23

Franchise Tax Board of California v. Construction Laborers Vacation Trust for Southern California, 679 F.2d 1307 (9th Cir. 1982), *vac. and remanded on jurisdictional grounds*, 103 S. Ct. 2841 (1983) ..... 10, 22

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) ..... 23

Hewlett-Packard Co. v. Barnes, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) ..... 25, 26, 27

Local Union 212 v. Local Union 212 IBEW Credit Union, 549 F. Supp. 1299 (S.D. Ohio 1982) ..... 23

Massachusetts Nurses Association v. Dukakis, 726 F.2d 41 (1st Cir. 1984) ..... 11, 26

Metropolitan Life Insurance Co. v. Massachusetts, No. 84-325 ..... 25, 27

Pervel Industries v. Connecticut Commission on Human Rights and Opportunities, 609 F.2d 214 (2d Cir. 1979), *cert. denied*, 443 U.S. 1031 (1980) ..... 25, 26, 27

Standard Oil of California v. Agsalud, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981) ..... 25, 26, 27

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 103 S. Ct. 2890 (1983) ..... *passim*

Stone & Webster Engineering Corp. v. Ilsley, 690 F.2d 323 (2d Cir. 1982), *aff'd, sub nom.* Arcudi v. Stone & Webster Engineering Corp., 103 S. Ct. 356 (1983) ..... 25, 26, 27

PAGE

***Federal Statutes:***

Employee Retirement Income Security Act of 1974
§ 3, 29 U.S.C. § 1002 ..... 10, 11, 18, 24
§ 4, 29 U.S.C. § 1003 ..... 10, 18
§ 514, 29 U.S.C. § 1144 ..... *passim*
§§ 101-110, 29 U.S.C. §§ 1021-1030 ..... 18
§§ 401-413, 29 U.S.C. §§ 1101-1113 ..... 18
§ 29 U.S.C. §§ 1001-1461 ..... 4

Social Security Amendments of 1967 § 402, 42 U.S.C. § 1395b-1 ..... 2, 17

***State Statutes:***

New York Insurance Law
§ 4403 ..... 26
article 43 ..... 3
article 44 ..... 4

New York Public Health Law
§ 2803 ..... *passim*
§ 2807 ..... 1, 2, 6, 19
§ 2807-a ..... *passim*
§ 4401 ..... 3
§ 4405 ..... 3
§ 4410 ..... 3
article 44 ..... 3
L. 1982, c. 536 ..... 6
cc. 536-538 ..... 5
L. 1978, c. 520 § 2 ..... 1
§ 4 ..... 1, 6

***Federal Rules:***

Supreme Court Rule 13 ..... 1

PAGE

***State Regulations:***

10 New York State Codes, Rules and Regulations
§ 86-1.2 ..... 3
subpart 86-1 ..... 3

***Miscellaneous:***

Black's Law Dictionary (5th ed. 1979) ..... 20
Governor's Memorandum on Approving NYPHRM, 1982 McKinney's Session Laws of New York 2608 ..... 1, 2
*Recommendations for Financing Inpatient Care,* Council on Health Care Financing (State of New York 1980) ..... 1, 6, 8

## Statement of the Case

### A. New York's Prospective Hospital Reimbursement Methodology

Public Health Law ("PHL") § 2807-a(6) (McKinney's Consolidated Laws of New York 1984-85 Supp.), the state statute involved, requires each of New York's three hundred general hospitals to establish equal charges for its inpatient services when the level of payment for the services is not determined by state-established or approved inpatient rates. The requirement is part of a three-year experimental program, known as New York's Prospective Hospital Reimbursement Methodology or NYPHRM, that will end on December 31, 1985 unless renewed by the Legislature. Opinion below at 7a; Governor's Memorandum on Approving NYPHRM ("Governor's Memorandum"), 1982 McKinney's Session Laws of New York 2608. NYPHRM is New York's most recent response to one of the most intractable problems of public health and welfare—the delivery of quality inpatient services, by financially sound hospitals, at reasonable, equitably apportioned cost. Opinion below at 3a, 4a, 7a, 15a-16a; district court opinion at 20a, 38a; Governor's Memorandum, *id.* at 2608-2609.* The program has three essential components: state-established inpatient revenue caps, *i.e.* income ceilings (PHL § 2807-a[1]-[4]; state-established or approved inpatient rates (§§ 2803[2], 2807[2], [3], 2807-a [1]) and equal charges (§ 2807-a[6] [statute involved]);

* NYPHRM's enactment was preceded by almost four years of study, negotiations, public hearings and comment. District court opinion at 20a; Governor's Memorandum, *id.* at 2608. The state Council on Health Care Financing conducted the major pre-NYPHRM study. It's final report, *Recommendations for Financing Inpatient Care* (State of New York 1980) ("Recommendations"), proposed a new system for financing inpatient care which, in accord with the Council's legislature mandate (L. 1978, L. 520, §§ 2, 4), was uniform, encouraged economy and equitably distributed cost. The proposed system, with modest changes, was adopted as NYPHRM. Excerpts from the Council's Recommendations are reproduced at 71-172 of the joint appendix in the United States Court of Appeals for the Second Circuit. Respondents' attorneys have transmitted copies of the Second Circuit appendix to the Clerk. *See* Supreme Court Rule 13(1),(3).

and state-mandated contributions to offset losses from bad debt and charity care. § 2807-a(1), (9).*

NYPHRM's comprehensive regulation of the field and inter-dependent components distinguish the program from New York's past responses to the problem of financing $8 billion in inpatient services its hospitals provide annually. Opinion below at 3a; A. ¶30.** NYPHRM's first component, an inpatient revenue cap established by the state Commission of Health for each general hospital, is the amount of money the hospital needs to provide inpatient services efficiently for a period of time, usually one year, and the amount of income it will be allowed to receive for the services. PHL § 2807-a(1); opinion below at 7a. Revenue caps, which did not exist in New York before NYPHRM, address fiscal stability and cost containment objectives since they permit each hospital to receive the money it needs for its inpatient services and no more. Opinion below at 7a; Governor's Memorandum, *id.* at 2608-2609.

NYPHRM's second component, state-established or approved inpatient rates (PHL §§ 2803[2], 2807[2],[3], 2807-a[1]) and equal charges (§ 2807-a[6] [statute involved]), distribute the cost of each hospital's inpatient services, as determined by its revenue cap, among the consumers of the services or their third party payors. The program has two categories of payors, cost payors and

* NYPHRM includes Medicare rates within state-established rates. The state's acquisition of jurisdiction over Medicare rates was a precondition to NYPHRM's operational status (L. 1982, c. 536, § 10[a]) and followed a waiver of federal authority granted by the United States Department of Health and Human Services ("HHS"). The HHS waiver is for a three-year period commencing on January 1, 1983. Second Circuit joint appendix ("A.") at 220; opinion below at 7a. It relies on § 402(a), (b) of the Social Security Amendments of 1967, 42 U.S.C. § 1395b-1(a)(1)(C), (b); A. 220. The legislation authorizes the Secretary to waive federal Medicare reimbursement standards to determine, in the context of an experiment or demonstration project, if state reimbursement standards, when applied to Medicare, reduce cost without adversely affecting patient care. See opinion below at 5a-7a, 14a-15a.

** References preceded by "A." are to pages of the Second Circuit joint appendix.

charge payors. Medicare, Medicaid, non-profit health insurance corporations ("non-profit health insurers" or "non-profit insurers")* and health maintenance organizations ("HMO's")** are cost payors. Cost payors meet approximately eighty-five percent, $6.8 billion, of the annual cost of inpatient services in New York. District court opinion at 21a; A. 386 ¶6.† They pay state-established or approved per diem rates set prospectively for each hospital.‡

* Non-profit health insurers are licensed under article 43, formerly article 9-C, of the New York Insurance Law (McKinney's Consolidated Laws of New York, 1984 Special Pamphlet.) The petition (at 4) and the NYPHRM legislation, which antedates the recodification of the Insurance Law, use the former article 9-C designation. *See e.g.* PHL § 2807-a(1), (4), (6), (11), (12). The petition (at 4) also identifies all non-profit health insurers in New York as "Blue Cross." See also Brief of *Amicus Curiae* Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States *amicus curiae* brief") at 4. In fact, there are twelve non-profit health insurers in the state that provide coverage for inpatient services. Five of the insurers, including the *amicus curiae*, Blue Cross and Blue Shield of Greater New York, are fiscally independent Blue Cross plans. They provide most of the coverage, either directly or indirectly. Three of the insurers, Capital Area Community Health Plan (Albany) and Genesee Valley Group Health Association, both also health maintenance organizations ("HMO's"), and Health Insurance Plan of Greater New York, provide coverage through contracts with Blue Cross plans. Four of the insurers, including Health Care Plan, Inc. (Buffalo), also an HMO, provide coverage themselves, *i.e.* without any relationship to a Blue Cross plan.

** HMO's are enrollee plans, certified under Public Health Law article 44, that provide comprehensive health services, directly or indirectly, for advance or periodic payments. PHL §§ 4401, 4405, 4410(1). There are sixteen HMO's in New York.

† All dollar amounts and percentages are for the 1983 calendar year, the last year for which data is available in the district court record. References preceded by "A." are to pages of the Second Circuit joint appendix.

‡ Prospective per diem rates for cost payors, whether established by the state Department of Health in the first instance, *i.e.* Medicaid and Medicare, certified by the Commissioner of that Department, *i.e.* HMO's and non-profit health insurers, or by other state officials, *i.e.* the state Superintendent of Insurance for non-profit health insurers, must conform with the state's Medicaid/Medicare rate methodology set forth in 10 New York Codes, Rules and Regulations ("NYCRR") subpart 86-1. PHL §§ 2803 (2), 2807-a(1) (¶4), (12); 10 NYCRR § 86-1.2(a).

Commercial health insurers, no-fault insurance, workers compensation, self-insured health plans, like petitioner's United Optical Workers Insurance Fund, and self-pay patients, *i.e.* patients without third party payors, are charge payors. Charge payors meet the remaining fifteen percent, of the annual cost of inpatient services in New York. A. 386 ¶6.* Since NYPHRM, they pay inpatient charges established by each hospital under PHL § 2807-a(6) (statute involved). Under § 2807-a(6), each hospital must bill all its charge payors at equal charges, *i.e.* at the same per service price, and must establish the charges at certain levels above its recent non-profit health insurer rate. *Ibid.*** There are two minor exceptions. Hospitals may

* Commercial insurers meet approximately eleven percent of the cost of inpatient services in New York, self-insured health plans and self-pay patients, together, approximately, four percent. A. 386 ¶6. The record does not identify the number of self-insured health plans operating in New York or their status under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Petitioner did not inform the lower courts of the number of self-insured plans which, like its own plan, are ERISA-covered, and respondents' efforts to obtain this information from the United States Department of Labor were unavailing. There are twenty-five state-licensed (*i.e.* under Insurance Law article 44) self-insured plans in New York that provide coverage for inpatient services. None is an ERISA-covered plan since the United States Department of Labor has exclusive jurisdiction over those plans.

** The difference between a hospital's cost, the basis for the rates paid by Medicaid, Medicare and article 43 non-profit health insurers, and a hospital's charges varies between twelve and fifteen percent under PHL § 2807-a(6)(b). Special obligations imposed on non-profit insurers support the differential for them. Under directives of the state Superintendent of Insurance, the corporations must offer policies to the community at large at modest premiums. A. 204-12. These community-rated policies usually insure high risks who would be denied commercial policies. A. 208-209 ¶30. The non-profit insurers subsidize the community-rated policies with premiums from their more selective, experience-rated group policies. A. 206 ¶26, 210 ¶33. The differential the non-profit insurers receive permits them to offer their experienced-rated group policies at premiums competitive with commercial insurers and, in turn, to subsidize the community-rated policies they are obligated to provide. A. 211-12 ¶35. See also Brief of *Amicus Curiae* Blue Cross and Blue Shield of Greater New York ("Blue Cross *amicus curiae* brief") at 4-7. *Contrast* petition at 5 n.3, attributing the state's interest in keeping Blue Cross plans (and, presumably, other article 43 insurers) competitive to a lobbying effort by "Blue Cross," a claim wholly without foundation in the record.

establish charges for HMO's through negotiated agreements approved by the state Commissioner of Health. § 2807-a(1) (¶15);* and they may continue negotiated agreements with self-insured health plans that were in effect on May 1, 1982, a date before NYPHRM was enacted. § 2807-(a)(b)(ii).**

State-established or approved inpatient rates and the complementary equal charges requirement, which did not exist in New York before NYPHRM, implement the revenue cap and address fiscal stability and cost-containment objectives. Hospitals are assured the income they need to fund their inpatient services, *i.e.* each hospital must establish its equal charges at a level which, when added to its rates, is "sufficient to generate the inpatient revenue authorized by . . . [its] revenue cap." PHL § 2807-a(6)(a).

* The state Commissioner of Health can approve negotiated hospital/HMO charges agreements only if they encourage patient self-management, thereby reducing the length of hospital stays, or include special benefits, *e.g.* discounts. PHL § 2807-a(1)(¶5).

** The PHL § 2807-a(6)(b)(ii) exception for pre-NYHRM hospital/self-insured health plan agreements adopts a recommendation of the Council of Health Care Financing (A. 141-42) which was informed that agreements of this kind were outstanding. A. 141. The petition (at 5 n.3) observes that state officials did not know how many agreements were subject to the § 2807-a(6)(b)(ii) exception albeit, given the basis for the Council's recommendation (A. 141), they knew there would be some. The observation is correct because the § 2807-a(6)(b)(ii) exception includes agreements between hospitals and ERISA-covered plans about which state authorities had, and have, no information. A. 162 ¶1. See p. 4 n.*.

The petition's further observation (at 5 n.3, 11), that NYPHRM "abrogated" outstanding negotiated charges agreements between hospitals and self-insured health plans, is false. PHL § 2807-a(6)(¶1) prohibits hospital/plan charges agreements after the January 1, 1984, the effective date of the equal charges requirement. The § 2807-a(6)(b)(ii) exception continues all pre-NYPHRM hospital/plan charges agreements in effect on May 1, 1982. Thus agreements made between July 20, 1982, the date NYPHRM was enacted (L. 1982, cc. 536-38), and the January 1, 1984 date for the equal charges requirement, including all the agreements entered into by the United Optical Workers Insurance Fund (A. 20 ¶3[a]), were made with the knowledge that negotiated charges were prohibited on and after January 1, 1984. Accordingly, none of these agreements could extend beyond January 1, 1984, and any agreement that purported to do so was prohibited by § 2807-a(6), not abrogated by it.

Overall inpatient services cost is contained because rates and charges are state-regulated, and no hospital's income can exceed its need, as determined by its revenue cap. § 2807-a(a) and p. 2. The rates and equal charges address a third objective as well, equitably apportioning the cost each hospital's inpatient services among all of its payors. Opinion below at 15a; L. 1978, c. 530, § 4 (new system for financing health care must assure equitable payment from all sources); *Recommendations for Financing Inpatient Care,* Council on Health Care Financing (State of New York 1980) ("Recommendations") at A. 131-35.

State-established or approved rates and the complementary equal charges requirement also resolve practical problems that diminished the effectiveness of New York's past responses to the problem of financing inpatient services. For example, NYPHRM required state Department of Health jurisdiction over Medicare rates (L. 1982, c. 536, § 10 [a]) to eliminate inconsistencies between state and federal cost containment strategies.* NYPHRM required specific differentials between cost and charge payors (PHL § 2807-a[6][b][i][¶¶1, 2]) and equal charges for all charge payors (§ 2807-a[6]) to eliminate cost-shifting among payors. District court opinion at 21a; A. 61 ¶12. In 1982, before the program's specific differentials became effective, charge payors paid one hundred and forty percent more than the average non-profit health insurer rate in some areas of the state and one hundred and twenty-five percent more than

* The state, before NYPHRM, could only establish or approve prospective rates for Medicaid, state government programs, non-profit health insurers and HMO's. PHL §§ 2803(2), 2807(2), (3). These prospective state rates limited each hospital's reimbursement from these sources to a predetermined amount and, to the extent they were applicable, effectively contained the cost of inpatient services. Opinion below at 3a, 4a; A. 57-58 ¶6, 59-60 ¶9. HHS, in contrast, could only establish retrospective rates for Medicare. Opinion below at 4a-5a; A. 58 ¶7. The rates did not limit Medicare reimbursement to a predetermined amount and were less effective in containing cost. *Ibid.* The state Department of Health's acquisition of jurisdiction over Medicare rates under NYPHRM allowed it to unify all rates under the state's more effective prospective methodology. Opinion below at 3a, 4a-7a.

average the non-profit insurer rate statewide. A. 62 ¶15. Before the program's equal charges requirement became effective, charge payors could, and did, combine to negotiate inpatient charges as a block. *Ibid.* The favorable terms they obtained for themselves were at the expense of other charge payors. *Ibid.**

NYPHRM's third component, mandated contributions from each hospital to reimburse losses from bad debt and charity care (PHL § 2807-a[1][¶4], [9]), completes the program. Again, the revenue cap is implemented and fiscal stability addressed by assuring each hospital partial reimbursement in the event of a payor default. Again, like state-established Medicare rates and the equal charges requirement, the component did not exist in New York before NYPHRM and resolves a practical problem. Before it was adopted, approximately five percent of inpatient services days in the state went unpaid because of payor defaults. A. 61 ¶13. The problem was most acute for inner-city hospitals that suffered a disproportionate share of defaults. *Ibid.*

The measure of NYPHRM as an experiment and the financial viability of the hospitals whose inpatient income, rates and charges are controlled by the program depend

* The petition (at 4-5, 9, 13, 20-21) creates the impression that NYPHRM economically favors large cost payors, like the Blue Cross plans, at the expense of small charge payors, like self-insured health plans. See also Central States *amicus curiae* brief at 2, 3, and Brief *Amicus Curiae* of Local 338 Health and Welfare Fund and Local 814 Welfare Fund ("Local 338 *amicus curiae* brief") at 3, 4-5, 7, 9, 10, 12-13. The program was not intended to, and does not in fact, do so. NYPHRM increased the per diem rates paid by Blue Cross plans seven to eight percent (A. 305, 306) and reduced their differentials as well as those of other non-profit health insurers. See p. 4 n.**. The program also increased Medicaid rates by some $50 to $70 million over its three-year life. Governor's Memorandum, *id.* at 2609. NYPHRM's equal charges requirement reduced the charges of charge payors, including self-insured health plans, that had been paying one hundred twenty-five percent to one hundred and forty percent more than the average non-profit health insurer rate. See text above. To the extent the equal charges requirement prohibited hospitals from granting new discounts to self-insured health plans, it eliminated an economic advantage those plans had obtained at increased cost to other charge payors.

on the maintenance of comprehensive regulation. As the Council on Health Care Financing said when it proposed the program: "It cannot be stressed too strongly that the reimbursement system . . . is an overall coordinated system with each component intra-related to the other components . . . . The . . . system cannot be applied on a selective basis . . . ." Recommendations, A. 132-33. The petition's opposing contention (at 5), that the prospective elimination of the equal charges requirement (PHL § 2807-a [6]) for self-insured health plans would have no discernable impact, ignores the inter-relationship among program components considered necessary by the Council and established by the Legislature. It also ignores the risk to the fiscal stability of hospitals that would follow the deregulation of charges to self-insured plans.

If, as the petition proposes (at 5), hospitals are foreclosed from billing self-insured health plans equal charges, and required, instead, to negotiate discount agreements with the plans, the hospitals' inpatient income will fall below the amount they need to provide inpatient services as soon as the first agreement takes effect. Inpatient income falls below need because the proposed discount charges will not meet the hospitals' revenue cap requirements, *i.e.* rates plus equal charges (PHL § 2807-a[6][b] and pp. 2-3), and, given continuing NYPHRM regulation of rates and equal charges for all payors except self-insured health plans, hospitals will not be able to make-up losses from plan discounts by shifting them to other payors. A. 390 ¶11 and pp. 6-7.

Moreover, inpatient income lost through negotiated discounts for self-insured health plans will increase with time. The proposed elimination of the equal charges requirement for the plans provides an incentive to other payors, *i.e.* those who pay equal charges or health insurance premiums, to establish themselves as self-insured plans in order to obtain the advantages of the deregulated discount charges. A. 391 ¶14. As the number of inpatients represented by self-insured plans increases, through the payor conversions to plan status, the volume of inpatient services provided at

discount charges increases, and the bargaining power of the plans to demand deeper discounts increases. *Ibid.* As a result, the hospitals' income falls continuously and increasingly below their need. A. 391 ¶¶13, 14.* Indeed, were the petition's proposal adopted, it would eventually restore and exacerbate pre-NYPHRM conditions. Hospitals would become fiscally unsound, if not insolvent, because their inpatient income would be insufficient. See pp. 2-3, 8-9. Bargaining power, not the cost of inpatient services, would determine charges, with large commercial health insurers and self-insured health plans receiving the economic advantage over small plans and self-pay patients. See pp. 7, 8-9. Differentials between self-insured health plans and

* The petition claims (at 5 n.3), erroneously, that the elimination of the equal charges requirement for self-insured health plans would affect only one percent of the inpatient income of the hospitals in New York and that the "danger[s]" that follow deregulation, noted just above, are attributable to a state animus against self-insurers or self-insured health plans.

The petition's one percent inpatient income figure (at 5 n.3) was offered by an accountant for the United Optical Workers Insurance Fund. Affidavit of Charles Pendola, sworn to May 1, 1984, at ¶3. It is intended to describe the impact of the pre-NYPHRM hospital/self-insured health plan agreements continued under the PHL § 2807-a(6)(b)(ii) exception to the equal charges requirement and of the agreements protected by the district court injunction that was briefly in effect. *Ibid.* It relies on the accountant's "experience," over an unspecified period of time, with "20 or so" unidentified hospitals of the three hundred hospitals in the state. *Ibid.* As appears, the figure is not reliable for the purpose it was offered below and cannot be accepted as a prospective measure of the statewide impact of continuing deregulation.

The petition (at 5 n.3) misrepresents the record when it claims that the state's opposition to the equal charges requirement reflects an animus against self-insurers rather than an interest in implementing NYPHRM's assurance that hospitals receive sufficient inpatient income from rates and equal, not discount, charges. See pp. 2-3, 4 n.**, 6-10. The state official the petition quotes in part (at 5 n.3) expressed concern about the economic consequences that would follow the negotiation of discount charges between hospitals and self-insured health plans under deregulation. A. 391 ¶14 and pp. 8-10. As the official notes (A. 391 ¶14), the consequences of concern result from the discounts plans receive, not from their self-insured status. Indeed, under New York law, employee welfare plans are "encouraged" because of their "great benefit to employees and their families." Insurance Law § 4401(a). See p. 4 n.*.

non-profit health insurers would collapse, diminishing the insurers capacity to provide policies to the public at large, and placing the cost of health care for individuals who are ineligible for group plans and cannot afford individual commercial policies on the public fisc. See p. 4 n.**.

### B. The United Optical Workers' ERISA-Covered Employee Welfare Plan

The United Optical Workers Insurance Fund maintains an employee welfare plan under § 4(a) of the Employee Retirement Income Security Act of 1974 ("ERISA" or "the Act"), 29 U.S.C. § 1003(a). Petition at 2. ERISA authorizes these plans, which may be administered by employers or employees, or both, to provide a variety of employee benefits, including medical, accident disability and death benefits, unemployment and vacation benefits, training programs, scholarship funds, prepaid legal services and day care. ERISA § 3(1), 29 U.S.C. § 1002(1). *See generally Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California,* 679 F.2d 1307 (9th Cir. 1982), *vac. and remanded on jurisdictional grounds,* 103 S. Ct. 2841, 2843-45 (1983) (employee welfare plan, providing vacations, claims ERISA preemption of state tax levies). *Contrast* petition at 10, stating that the "sole function and purpose [of] an employee welfare plan is to provide hospital care or benefits," seeming to claim that all benefits must be hospital-related.

The United Optical plan is administered jointly by employers and employees (A. 18 ¶1) but relies entirely on employer contributions, negotiated in collective bargaining. A. 19-20 ¶3. *Contrast* petition at 3, stating that employer contributions are the "primary source" of plan funding without identifying any other sources. The plan provides accident, disability (stipend if at home because of accident or illness) and death benefits, in addition to medical benefits, which include paid doctor vists and laboratory fees, standard major medical coverage and all hospital expenses for up to one hundred and twenty days of care. A. 22. Fifteen

hundred individuals, employee plan members and their dependents, in five states, New York, New Jersey, Connecticut, Massachusetts and Florida, are eligible for the benefits. A. 18-19, ¶¶1, 2.* Three of the states in which the plan operates, New York, New Jersey and Massachusetts, have experimental NYPHRM programs. Opinion below at 6a; *see generally Massachusetts Nurses Association* v. *Dukakis*, 726 F.2d 41, 42, 45-46 (1st Cir. 1984) (hospital inpatient income controls, alleged to interfere with collective bargaining, upheld against NLRA preemption claim).

Effective January 1, 1983, the trustees of the United Optical plan decided to self-insure, a choice ERISA leaves to their discretion. ERISA § 3(1), 29 U.S.C. § 1002(1) (employee welfare plans may provide authorized benefits "through the purchase of insurance or otherwise," *e.g.* through self-insurance). A. 19-20 ¶3. The trustees then terminated United Optical's contracts with Blue Cross plans that had insured its inpatient services benefits and retained an agent to represent the plan's interests as a self-insurer. A. 20 ¶3a, 29 ¶8.** The agent represented some

* The petition (at 2) characterizes United Optical plan members and their dependents as "medically indigent." The term is normally confined to individuals who receive public medical assistance, *i.e.* Medicaid, but are not eligible, because of excess income and resources, for other public assistance programs, *e.g.* Aid to Families with Dependent Children, which address more generalized needs. The petition (*ibid.*) concedes that United Optical plan members earn too much money to be Medicaid-eligible. Notwithstanding this concession, the petition (*ibid.*) claims that the members of the United Optical plan would leave their hospital bills unpaid if plan benefits were withdrawn or reduced. The petition does not explain why they would do so, and the result appears unlikely, given the availability, in New York, of individual health insurance policies from non-profit insurers at modest cost. See p. 4 n.**.

** According to the United Optical plan's agent, self-insured health plans realize economies on inpatient services benefits in five ways, which he does not distinguish in importance: a) negotiating price discounts with hospitals; b) keeping reserve funds in an interest-bearing account; c) conducting case reviews to eliminate unnecessary medical procedures and reduce lengths of stay; d) coordinating benefits and collections with other insurers; and e) reducing administrative costs. A. 26-28 ¶¶4-8.

fifty self-insured ERISA health plans when United retained him, and, negotiating with hospitals for the plans as a block, had obtained about one hundred discount agreements. A. 26 ¶4 (data in record not exact). Most of the agreements were five percent above the hospitals' rates for Blue Cross plans and other non-profit health insurers; the rest were for lower discounts or no discounts. A. 20 ¶3(a); 26 ¶5 (data in record not exact). *Contrast* petition at 4, 12 n.9, claiming that all one hundred agreements were for discounts of five percent above the non-profit insurer rate. To the extent United Optical's agent obtained discounts for the fifty self-insured plans he represented, the charges of other charge payors, to whom hospitals shifted their losses, increased See pp. 7, 8-9.

For 1983, the United Optical plan's first year as a self-insurer, its agent projected savings of $100,000 to $120,000 from all self-insurance-related economies (see p. 11 n.**), including United Optical's participation in the discount agreements. Petition at 4; A. 26-27 ¶5. Notwithstanding anticipated savings from self-insurance, United incurred losses from its medical benefits in 1983, and, before January 1, 1984, the effective date of NYPHRM's equal charges requirement (PHL § 2807-a[6][¶1]), plan trustees reduced non-hospital medical benefits. A. 29 ¶3(a). See petition at 3, noting that United's hospital benefits remained the same under self-insurance but omitting the fact the plan's non-hospital medical benefits were reduced.

### C. Proceedings In The District Court And The Opinion Below

Petitioner commenced this action in the United States District Court for the Southern District of New York on December 1, 1983 (A. 2 [12/1/83 entry]), a month before NYPHRM's equal charges requirement became effective. PHL § 2807-a(6) (¶1). He sought declaratory and injunctive relief against the equal charges requirement, § 2807-a(6) (A. 12-13 ¶¶1, 2), claiming that if it were enforced, the United Optical plan would have to reduce

benefits, forego its recently adopted status as a self-insurer and return to purchasing insurance from Blue Cross plans. Petition at 5; see also A. 12 ¶24.*

The action was initially submitted to the district court on petitioner's motion for a preliminary injunction. A. 14. The motion relied on the multiple legal theories set forth in the complaint. A. 8-11 ¶¶12-22.** However, at the suggestion of the court and with consent of the parties and the *amicus curiae*, Blue Cross and Blue Shield of Greater New York, the moving and opposing papers were read as cross-motions for summary judgment on the question of whether PHL § 2807-a(6) was preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because it required hospitals to bill United Optical's ERISA-covered, self-insured health plan equal charges. District court opinion at 40a ¶1.

* Petitioner has yet to explain why these presumed consequences follow the enforcement of NYPHRM's equal charges requirement. Their brief examination reveals that they do not and that petitioner is really describing some, but not all, of the United Optical plan's options in straightened economic times, not the consequences of state action. For example, the United Optical plan need not reduce benefits even if the prohibition against new discount agreements established by equal charges requirement yields increased costs, a result itself in doubt. See pp. 11 n.**, 12. The plan trustees may choose to reduce benefits, as they did in 1983, before the equal charges requirement had any application. See p. 13. Alternatively, the trustees may choose to supplement the employer contributions that now fund all plan benefits (see p. 10) with employee contributions, an option petitioner has not yet noted, and a low-cost device, routinely adopted by employee welfare plans, to maintain benefit levels. Equally, United's trustees may, but need not, forego self-insurance, albeit there is no reason for them to do so since they have been advised that self-insurance allows economies that have no relation to discount agreements. See p. 11 n.**. If the plan trustees decide to purchase insurance, they may buy it from Blue Cross plans or any other health insurer. It may even be to trustees' advantage to seek out a commercial insurer, which while subject to the equal charges requirement, competes with Blue Cross plans by offering low premiums on experienced-rated group policies the plan would buy. See p. 4 n.**; A. 106 ¶26.

** The complaint alleged claims for relief under the contracts clause, the interstate commerce clause, the equal protection clause, the anti-trust laws and ERISA. Petitioner recently withdrew, with prejudice, all of the recited claims except the anti-trust claim and the ERISA preemption claim that is now before this Court. Stipulation dated March 25, 1985.

The district court issued its opinion and order on March 12, 1984. The court held that PHL § 2806-a(6) was preempted by ERISA because it "relate[d] to" the United Optical plan under § 514(a) of the Act, 29 U.S.C. § 1144(a), and was not saved by the ERISA exceptions from preemption for state laws regulating insurance, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and for interpretations of § 514 (a) that would impair other federal laws. § 514(d), 29 U.S.C. § 1144(d). District court opinion at 23a-39a.* The court's finding that the equalized hospital charges PHL § 2807-a(6) requires "relate[d] to" the plan under § 514(a) relied, principally, on the broad reading this Court gave that language in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1963). District court opinion at 23a-27a. ERISA's legislative history, as set forth in *Delta Air Lines*, and ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2), defining state and local entities whose laws are subject to ERISA preemption, or state and local laws that ERISA preempts, as those purporting "to regulate, directly or indirectly, the terms and conditions of [ERISA-covered] employee . . . [welfare] plans," are cited as supporting the court's conclusion. District court opinion at 23a-24a, 25a.

The district court also identified two supposed ERISA § 514(a), 29 U.S.C. § 1144(a), 'relationships' between the equal charges requirement and the United Optical plan: increased plan cost or reduced plan benefits allegedly caused by equal charges (district court opinion at 25a-26a; but see pp. 11 n.**, 12, 13 n.*); and frustration of ERISA's goal of uniform, multistate administration allegedly caused by equal charges. District court opinion at 24a-25a, 38a. A third point, the alleged specificity of PHL § 2807-a(6) in prohibiting hospitals from entering into new, *i.e.* post-January 1, 1984, charges agreements with self-insured health plans was also noted. *Id.* at 26a-27a.

* We do not summarize the district court's examination of PHL § 2807-a(6) under the state insurance law and impairment of other federal laws exceptions from ERISA preemption because they are not reached by the opinion below. See district court opinion at 28a-38a.

On November 26, 1984, a unanimous panel of the United States Court of Appeals for the Second Circuit reversed the district court. Opinion below at 1a-16a. At the outset of its opinion, the court acknowledges that the spiraling cost of hospital care has been a serious public problem for several decades. *Id.* at 3a. It then traces the history of the more and less successful cost containment efforts, respectively, of Medicaid and Medicare (*id.* at 4a-5a) and the federal government's interest, since at least 1967, in experimenting with state methodologies that increase efficiency without impairing quality of care. *Id.* at 5a. See pp. 2 n.*, 6 & n.*. The court concludes its history by noting the most recent state-federal effort, NYPHRM, and the four similar demonstration projects in other states. *Id.* at 6a-7a, 15a. NYPHRM is described as an exercise of the state's police power (opinion below at 10a), approved by HHS and ratified by Congress (*id.* at 6a), whose equal charges requirement fairly and flexibly apportions cost, free of the administrative difficulty of establishing specific rates for all inpatient services. *Id.* at 15a-16a.

When the court turns to the text of ERISA, it finds initial assistance for interpreting § 514(a), 29 U.S.C. § 1144(a), in § 514(c)(2), 29 U.S.C. § 1144(c)(2), the same subsection cited by the district court in support of the preemption of PHL § 2807-a(6). See p. 14. The Court of Appeals reads subsection § 514(c)(2) as referring to the state and local laws ERISA preempts (rather than to state and local law-making bodies whose laws ERISA may preempt) and as limiting the preempted laws to those that regulate the "terms and conditions" of covered plans. § 514(c)(2); opinion below at 9a & n.1. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), is cited as supporting the court's reading of § 514(c)(2), and the use of that subsection in interpreting § 514(a).*

* The court later describes the state and local laws preempted by § 514(a), 29 U.S.C. § 1144(a), more broadly, *i.e.* as laws that affect "the structure, the administration or the type of benefits provided by an ERISA plan . . . ." Opinion below at 12a. See petition at 9-10, criticizing the court's reference to the "terms and conditions" language in § 514(c), 29 U.S.C. § 1144(c), but omitting mention of the court's later reference to "structure," "administration" and "type of benefits."

The court next acknowledges the broad reading this Court gave the "relate to" language in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983), as well as the limitations imposed on that language by *Delta Air Lines*, i.e. state laws that affect plans in a tenuous, remote or peripheral manner do not "relate to" plans. 103 S. Ct. at 2901 n.21. Opinion below at 10a, 11a-12a. It then concludes that the PHL § 2807-a(6) equal charges requirement has, at best, a remote effect on plans, within the limitations on § 514(a) expressed in *Delta Air Lines*, and, therefore, does not "relate to" plans for purposes of ERISA preemption. Opinion below at 10a.*

The court addresses, and rejects as insufficient, the three considerations the district court thought established an ERISA § 514(a), 29 U.S.C. § 1144(a), 'relationship' between PHL § 2801-a(6) and the United Optical plan. Opinion below at 11a-13a. See p. 14. Increased costs (or reduced benefits to offset them) are recognized as a possible consequence of all state and local regulation, whether of hospital charges or telephone rates, from which

* The petition (at 9, 11) claims, wrongly, that the court held PHL § 2807-a(6) free of ERISA preemption on the erroneous premise that it had to do so unless it found an unavoidable conflict between the state statute and a "term" or "condition" of the United Optical plan. See also Central States *amicus curiae* brief at 7, 8. The court's statement on point is: "[A] state's promulgation of hospital rate schedules [, *i.e.* equal charges,] should not be found to 'relate' to 'the terms and conditions of employee benefit plans' unless this conclusion is unavoidable." Opinion below at 11a. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), is cited. *Ibid.*

The statement does not depend on an erroneous premise. *Alessi* held a state statute preempted by ERISA on a traditional preemption-by-implication analysis, which, as the opinon below observes (at 11a), found the statute and federal law in "unavoidable" conflict. 451 U.S. at 522. *See Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. at 2900 n.15, noting distinction between the express preemption analysis under § 514(a) pursued there and the *Alessi* by-implication analysis. To the extent that court's brief statement may be read as a preemption-by-implication analysis and a finding that PHL § 2807-a(6) is not preempted, it is not error. It simply reflects the court's undertaking of the *Alessi* analysis, in addition to the *Delta Air Lines* analysis, on which its express holding depends. The holding, stated in the text just above, relies exclusively on the *Delta Air Lines*, citing the attentuated effect of § 2807-a(6) on ERISA-covered plans.

ERISA plans have no special protection. Opinion below at 11a-12a. ERISA's goal of national uniformity is recognized as serving plan interests in the discretionary choice of form of administration and benefits, not in nationwide uniformity of price, a goal which United Optical's preference for negotiated charges would not serve in any event. *Id.* at 12a-13a. The PHL § 2807-a(6)(b)(ii) reference to pre-NYPHRM negotiated agreements, *i.e.* "payment . . systems," that are permitted to continue after the January 1, 1984 effective date of the equal charges requirement, is recognized as a legislative effort to temper the treatment of self-insured health plans to reflect differences among them or between them and other charge payors. *Id.* at 12a n.2.*

One Circuit Judge on the Court of Appeals panel, writing for himself, believed that PHL § 2807-a(6) would also be saved from ERISA preemption by the § 514(d), 29 U.S.C. § 1144(d), exception for interpretations of §514(a), 29 U.S.C. § 1144(a), that would impair other federal laws. Opinion below at 13a-16a. According to the Judge, a federal statute, § 402(a), (b) of the Social Security Amendments of 1967, 42 U.S.C. § 1395b-1(a)(C), (b), authorizing the HHS secretary to grant Medicare waivers for experimental programs involving state methodologies, the authority for New York's NYPHRM waiver (A. 220-24), would be impaired if § 2807-a(6) were preempted for hospital charges to ERISA-covered, self-insured health plans.

## The Writ Should Be Denied

**The Decision Below Is Correct Because ERISA-Covered Employee Welfare Plans And NYPHRM's Equal Charges Requirement Cannot Relate To Each Other Under ERISA § 514(a). There Is No Conflict With Decisions Of This Court Or With Decisions From The Circuits On This Point.**

ERISA and NYPHRM, including the PHL § 2807-a(6) equal charges requirement in issue, regulate within dis-

* Record references cited at p. 5 n.** include the joint appendix references, A. 141 ¶2, 162 ¶11, which the petition (at 9 n.5) suggests, wrongly, disclose a different or more intense state interest in regulating self-insured health plans.

crete fields that cannot "relate to" each other under § 514 (a) of the Act, 29 U.S.C. § 1144(a). ERISA, through Congress' commerce clause power, regulates the field of covered, *i.e.* non-exempt, employee pension and welfare plans.* ERISA establishes rights and relationships among employee welfare plan managers, plan members and fiduciaries and standards for reporting, disclosure and fiduciary responsibility. ERISA §§ 101-110, 401-413, 29 U.S.C. §§ 1021-1030, 1101-1113. ERISA authorizes a variety of welfare plan benefits, *e.g.* medical and vacation benefits, scholarships, day care, from which a plan may select some or all (§ 3[1], 29 U.S.C. § 1002[1]); it permits plans to provide the benefits "through the purchase of insurance or otherwise," *e.g.* through self-insurance (*ibid.*); and, subject to the few legislatively-mandated practices noted, *e.g.* reporting and disclosure, it generally reserves matters of plan design to the representatives of employers, employees, or both, who manage the plan, and, ultimately, to plan funding, determined through collective bargaining. *See* ERISA §3 (1), 29 U.S.C. § 1002(1) (employers, employees, or both, may administer covered plans); *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511, 525 (1981) (most choices for more intensely regulated pension plans left to private parties); and p. 11 (United Optical employee welfare plan benefits, administration and funding described).

ERISA has a unique feature. Under § 514(a), 29 U.S.C. § 1144(a), it expressly preempts state laws that "relate to" covered employee pension and welfare plans, rather than, as might be anticipated, state laws that "relate to" sections of the Act. Section 514(a) was adopted in this form, after extended deliberation, to protect from state interference both the subjects on which ERISA affirmatively legislates

* Certain employee pension and welfare plans are exempt from ERISA, principally those maintained by churches or by governments for their own employees or to comply with Workers Compensation and Unemployment Insurance laws. ERISA § 4(b), 29 U.S.C. § 1003(b).

and the subjects it reserves to plan discretion.* *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 2900-2901, esp. n.18-n.20 (1983).

NYPHRM is an experiment in financing hospital inpatient services, created by the New York Legislature under its police power and a federal waiver of authority over Medicare rates granted by the United States Department of Health and Social Services. See pp. 2-3. The program, which expires on December 31, 1985, affirmatively controls all of the inpatient income of the three hundred general hospitals in the state. See p. 1. It does so through three essential components—inpatient revenue caps (PHL § 2807-a[1]-[4]), inpatient rates (§§ 2803[2], 2807[2],[3], 2807-a [1] with complementary equal charges (§ 2807-a[6]), and contributions to offset losses from bad debts and charity care (§ 2807-a[1],[9])—all established or approved by state agencies, or, for the equal charges requirement in issue (§ 2807-a[6]), by hospitals under state-established standards. See pp. 2 n.*, 3 n.‡. The equal charges requirement obligates each general hospital to bill its non-rate, charge payors at the same per service price. PHL § 2807-a(6) (¶1). Subject to two minor exceptions (see pp. 4-5), it also obligates each hospital to establish its charges at a level which, when added to its rates, is sufficient to meet its inpatient income needs and is at a certain interval above its

* Respondents give the broadest possible meaning to the term "subject." It includes any matter on which ERISA has affirmatively legislated, and any matter a covered plan is empowered to decide, with or without recourse, to the Act. Given this definition, it is unnecessary to now decide whether the phrase, "purports to regulate, directly or indirectly, the terms and conditions of employee . . . [welfare] plans," in ERISA § 514(c)(2), 29 U.S.C. § 1144 (c)(2), refers to state and local laws ERISA preempts or to state and local entities whose laws ERISA may preempt. See opinion below at 9a & n.1 and pp. 14, 15. It is also unnecessary to decide whether "terms and conditions" refers to matters literally set forth in covered plans, *e.g.* the benefits they provide, or to those matters and, in addition, plan structure, administration and choice of benefits. See opinion below at 12a and p. 15. See also petition at 10; Local 338 *amicus curiae* brief at 10; Blue Cross *amicus curiae* brief at 8.

recent non-profit health insurer rate. *Id.* at § 2807-a(6)(a), (b) and pp. 4-5.*

The PHL § 2807-a(6) equal charges requirement cannot "relate to" ERISA, to the United Optical plan, or to any other ERISA-covered, employee welfare plan, whether self-insured or not, under ERISA § 514(a), 29 U.S.C. § 1144(a), because the state statute regulates a subject—hospital prices for inpatient services—that is outside ERISA's field of regulation.** ERISA has not affirmatively legislated the price of inpatient services, and employee welfare plans cannot decide the price of these services through the exercise of the discretion ERISA reserves to them. Indeed, the plans are in the same position with respect to inpatient services under ERISA as they were before ERISA. In neither circumstance, could they decide the price of the services. NYPHRM's control over the price of inpatient services, through state-established or approved rates and the complementary PHL § 2807-a(6) equal charges require-

* Non-profit health insurers, *e.g. amicus curiae* Blue Cross and Blue Shield of Greater New York, receive differentials, *i.e.* discounts, of twelfe to fifteen percent below the equal charges level. See p. 4 n.**.. The discounts are justified by the non-profit insurers' obligation to issue policies to the public at reasonable cost, and their need to subsidize these policies with the proceeds from the sale of group health insurance policies which they sell in competition with commercial insurers. *Ibid.* ERISA-covered plans do not share the non-profit insurers' obligations, and so discounts for them, neogtiated or otherwise, are not justified. However, since ERISA preemption depends on the exercise of power, here whether the state can regulate the price of impatient services, not its degree, *i.e.* what the regulated price of inpatient services is, the fact that covered plans pay equal charges while non-profit health insurers pay less is irrelevant in this case. Respondents have, therefore, restyled the question presented to omit the petition's reference (at i) to non-profit health insurer discounts.

** To "regulate" means to fix, establish or control; . . . to direct by rule or restriction; to subject to governing principles or laws." Black's Law Dictionary at 1156 (5th ed. 1979). ERISA's field of regulation, therefore, encompasses any matter it can "subject to governing principles" and, by extension, any matter its covered-plans have the power to "establish" or decide. *Ibid.* Hospital prices for inpatient services are not among the matters ERISA can govern, or covered plans can decide.

ment, reciprocates the lack of price control authority by ERISA and ERISA-covered plans, and places the subject of price firmly and exclusively within the field of NYPHRM regulation.*

The reciprocal relationship between the ERISA and NYPHRM fields of regulation with respect to the price of inpatient services applies, in reverse, to inpatient services as employee welfare plan benefits. The relationship is readily illustrated and places the subject of inpatient services as plan benefits outside the field of NYPHRM regulation and firmly and exclusively within the field of ERISA regulation. NYPHRM does not legislate, *i.e.* mandate, inpatient services as plan benefits, and hospitals cannot decide that inpatient services will be plan benefits in the exercise of the discretion NYPHRM reserves to them. Hospitals, before and after NYPHRM, are in the same relation to inpatient services as plan benefits, as are plans, in relation to the price of inpatient services before and after ERISA, *i.e.* without any regulatory authority. As the plans' lack of authority over the price of inpatient services and NYPHRM's control over it place price outside the field of ERISA regulation and within the field of NYPHRM regulation, so the hospitals, now NYPHRM's, lack of authority over inpatient services as plan benefits, and the plans' control over them as benefits place this aspect inpatient services outside the field of NYPHRM regula-

* That hospitals and plans could negotiate the price of inpatient services before NYPHRM does not mean that price was then decided by plans, *i.e.* was within ERISA's field of regulation. The pre-NYPHRM power to decide the price of inpatient services for plans and other charge payors resided with hospitals. The hospitals power over the subject is evidenced by three facts: 1) no negotiated charges agreement could be concluded without a hospital's acquiescence, or consent, or in face of its refusal to agree; 2) if a hospital refused to negotiate or to agree, plans and other prospective price negotiators were bound to pay charges the hospital established unilaterally; and 3) the hospital could revise its charges, but the plans and other prospective negotiators could not compel it to do so. NYPHRM succeeded to the hospital's power to decide charges and, in effect, directs them, under PHL § 2807-a(6) (with the two exceptions noted at pp. 4-5), to refuse to negotiate.

tion and within the field of ERISA regulation. In sum, ERISA and NYPHRM operate within discrete fields of regulation with respect to two different aspects of inpatient services. ERISA-covered plans can decide whether inpatient services will be plan benefits but not their price. NYPHRM can decide the price of inpatient services but not whether they will be plan benefits.

Respondents' analysis, limiting the preemptive reach of the term "relate to" in ERISA §514(a), 29 U.S.C. §1144(a), to ERISA's field of regulation, and leaving state laws, like PHL § 2807-a(6), intact because they are outside that field, is consistent with the discussion of the term "relate to" in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 2900-2901 (1983). There, this gives Court "relates to" its normal meaning which is "connection with or reference to." *Id.* at 2900. The Court then identifies ERISA as " 'regulat[ing] the field of employee benefit plans' " (*id.* at 2901 [quoting legislative history]; *see also id.* at 2901 n.20), and limits the word "connection" to connection with ERISA-covered plans (*id.* at 2900). *Contrast* petition at 25, noting the Court's initial definition but omitting the further elaboration. The only conclusion available from the Court's discussion is the one respondents have drawn. Namely, only state laws that have an ERISA-field "connection" or a covered-plan "connection" come within the term "relate to" in § 514(a).

To the extent that respondents' analysis also requires the state law "connection" to ERISA's field of regulation or to covered-plans to involve a subject which ERISA regulates or plans can decide, it observes a point of law cited by the Court in *Delta Air Lines.* Only state laws that have a cognizable connection to ERISA or to covered-plans come within the term "relate to" and are preempted by § 514(a), 29 U.S.C. § 1144(a). 103 S.Ct. at 2901 n. 21. *See Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California,* 679 F.2d 1307, 1313 (*Tang,* C.J. dissenting) (9th Cir. 1982), *vacated remanded on jurisdictional grounds,* 103 S.Ct. 2841 (1983) (state laws

must have a "regulatory effect" on plans to be preempted); *Local Union 212* v. *Local Union 212 IBEW Credit Union*, 549 F. Supp. 1299, 1302 (S.D. Ohio 1982) (same). Conversely, state laws, like PHL § 2807-a(6), without a cognizable connection to ERISA or to covered plans, *i.e.* those which do not regulate subjects that ERISA legislates or plans can decide, do not "relate to" plans and are not preempted by § 514(a) although they may effect plans, *e.g.* they may result in increased cost or reduced benefits. *See Shaw* v. *Delta Air Lines, Inc., supra*, and cases cited just above; *American Progressive Life and Health Insurance Co.* v. *Corcoran*, 715 F.2d 784, 787 (2d Cir. 1983) (state law establishing commissions on sales of life insurance policies saved from ERISA preemption under the exception for state insurance laws, and law's slight effect plan benefits held not sufficient to warrant its characterization as "govern[ing]" plans); and *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (Blue Shield/pharmacy price agreements affecting insureds' benefits held not to involve the business of insurance because, *inter alia*, the pharmacies were non-insurance-related, third parties, the same status hospitals have in relation to covered plans under PHL § 2807-a[6]).

Indeed, were state laws capable of preemption under ERISA § 514(a), 29 U.S.C. § 1144(a), only because, as the petition (at 20-21, 23 n.17) claims, they have an economic effect on covered plans, two extraordinary and anomalous consequences would follow. First, as the opinion below observes (at 10a, 11a-12a), plans would obtain an economic advantage over all other purchasers of goods and services because they would be immunized from state and local price and wage controls in myriad transactions, including paying for plan utilities, plan employees and plan benefits.*

* The petition (at 10, 21) attempts to confine its economic effect theory of ERISA preemption to payments for plan benefits, which it characterizes as the "business" of the plans (*id.* at 21), as distinguished from payments for plan utilities, employee salaries, and the

*(footnote continued on next page)*

Second, subjects commonly addressed by state and local action would be immune from regulation to the extent they involve plans. For example, if state and local laws regulating utility rates and minimum wages are preempted under § 514(a) because the amount of plan telephone bills and plan employee salaries establish a 'relation' between the laws and plans, the subjects of the laws, telephone rates and minimum wages, become nonregulable with respect to plans. They become so because the decisions of the state and local agencies that are empowered to act on rates and wages have been nullified by 514(a) and, given ERISA's field of regulation is limited to subjects ERISA legislates and plans can decide, no substituted rates or minimum wage standards can be provided by plans. As noted (p. 23 n.*), if preemption of state and local laws under § 514(a) depends on economic effect, a plan's payment for benefits is indistinguishable from its payment of the telephone bill or the salaries of its employees. Thus, the same result obtains when plans pay regulated prices for benefits like inpatient services, college tuition or day care.* If the state or local

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like, which it accepts as the 'cost of doing plan business.' *Id.* at 10. *See also* Central States *amicus curiae* brief at 9. The distinction is a false under petition's own theory. A plan's payment for any good or service, whether the telephone bill or inpatient services, is an expenditure of plan funds with, perforce, an economic effect on the plan. Accordingly, if, as the petition (at 20-21, 23 n.17) contends, state laws are preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because of their economic effect on plans, a law that regulates telephone rates is preempted to the same extent as a law that regulates the price of inpatient services. Notably, to the extent either or both laws increase plan expenditures, which are not offset by increased income, the plan must undertake economies, including possible reductions in plan benefits.

* ERISA-covered plan benefits are not confined to hospital benefits as the petition (at 10, 21) suggests, but may include scholarships and day care among others. ERISA § 3(1), 29 U.S.C. § 1002(1) and p. 10. Thus, even if the petition's attempted limitation of ERISA preemption to plan payments for benefits, as distinguished from plan payments for other costs, were followed (see p. 23 n.*), plans would receive wide-ranging immunity from price controls and numerous subjects commonly addressed by state and local action

*(footnote continued on next page)*

law is preempted under § 514(a), the subject becomes non-regulable because plans cannot decide the price of the benefits in lieu of the duly constituted state and local agencies.

The petition cites two decisions of this Court, *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), and *Alessi* v. *Raybestos-Manhattan Inc.*, 451 U.S. 504 (1981), which have upheld the preemption of state laws under ERISA § 514(a), 29 U.S.C. § 1144(a), four decisions from the Circuits that have done so,* and a matter now before this Court, *Metropolitan Life Insurance Co.* v. *Massachusetts*, No. 84-325, on which the petition (at 11-13) principally relies, where the outcome necessarily is in doubt.** None of

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would be immunized from regulation. For example, plan scholarships at state universities would be immunized from state-established tuition; plan payments for public day care would be immunized from locally established charges; and, in neither case, could a plan establish charges for the services in lieu of the state or locality.

* *Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom., Arcudi* v. *Stone & Webster Engineering Corp.*, 103 S. Ct. 356 (1983) (statute mandating employer contributions for life and health insurance for former employee preempted); *Standard Oil of California* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981) (statute mandating employers to provide prepaid comprehensive health care benefits preempted); *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities, aff'd*, 609 F.2d 214 (2d Cir. 1979), *cert. denied*, 443 U.S. 1031 (1980) (statute mandating pregnancy disability benefits preempted); *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *affd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (statute comprehensively regulating health care service plans, including same subjects as ERISA, preempted; statute's regulation of third party health care providers, *e.g.* hospitals, not in issue, 425 F. Supp. at 1297 n.10).

** The petition (at 12, 13) claims similarities between *Metropolitan* and this case sufficient to make their outcomes in this Court depend on each other. The two cases have virtually nothing in common. *Metropolitan* involves a Massachusetts statute that requires health insurance policies to include minimum coverage for certain mental and nervous disorders. The statute is challenged as ERISA-preempted by covered plans that purchase health insurance on the theory that it mandates plan benefits. It is defended by Massachusetts solely on the ground that it is a law regulating insurance and saved from preemption under the ERISA exception for those state laws. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

*(footnote continued on next page)*

**the decisions provides authority for the preemption of PHL § 2807-a(6) by § 514(a), or is in conflict with the decision below, because none considers a state law that regulates the price of a good or service plans buy, whether as a plan benefit, like the inpatient services regulated as to price by § 2807-a(6), or for any other purpose. See pp. 23 n.*, 24 n.**.**

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Brief for Appellee at i, 12-34. PHL § 2807-a(6), the statute involved in this case, regulates the price of inpatient services. The statute does not mandate plans to provide the services as benefits. It was held free of ERISA-preemption below under § 514(a), 29 U.S.C. § 1144(a), not, as the petition (at 12) states, saved from § 514(a) preemption by "an expansive interpretation of the [ERISA] exceptions to preemption." See also *id.* at 18. As appears, *Metropolitan's* disposition depends on the status of the Massachusetts statute as an insurance law under § 514(b)(2)(A) and, whatever the outcome, the status of PHL § 2807-a(6) as a price control regulation under § 514(a) will not be affected. *Contrast* petition at 13.

The petition (at 12-13 & n.10) is also mistaken when it claims that differences between the Massachusetts and New York laws make it "virtually impossible" (*id.* at 13 n.10) to operate the United Optical plan in the same manner in the two states. New York, like Massachusetts, requires minimum coverage in health insurance policies. Insurance Law § 4303. See also Central States *amicus curiae* brief at 5-6. Thus, the incentive for plans to self-insure that the petition (at 12 & n.10) attributes to Massachusetts, *i.e.* avoidance of mandated minimum coverage, is also present in New York. Second, Massachusetts is a NYPHRM state (see pp. 10-11), and its non-profit health insurer rate is the same as all other payor rates and charges. *Massachusetts Nurses Association* v. *Dukakis*, 726 F.2d 41, 45-46 (1st Cir. 1984). Thus, the incentive for plans to purchase non-profit insurance the petition (at 12 & n.10) attributes to New York because of its non-profit insurer differentials does not become a dis-incentive in Massachusetts. Notably, three of the five states in which the United Optical plan operates have NYPHRM programs, *i.e.* New York, New Jersey and Massachusetts, substantially facilitating the plan's uniform, interstate operation. See pp. 10-11.

* Two of the four Circuit decisions the petition cites, *Stone & Webster Engineering Corp.* v. *Ilsley*, *supra*, and *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities*, *supra*, like the decision below, are from the Second Circuit. They cannot support the conflict among the Circuits on the question presented that the petition (at 15-25) claims even if they opposed the decision below. Of the two other Circuit cases the petition cites, one, *Standard Oil of California* v. *Agsalud*, *supra*, involved comprehensive mandatory benefits, not the regulation of the price their third party providers charged, and the other *Hewlett-Packard Co.* v. *Barnes*, *supra*, disclaimed any consideration of third party providers.

All of the decisions the petition cites conform with respondents' analysis (see pp. 20-23) because the state laws held preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), regulated subjects within ERISA's field of regulation, *i.e.* subjects ERISA legislates* or subjects ERISA reserves to the discretion of covered plans.** None of the decisions opposes the premise of respondents' analysis that characteristics that include state laws within ERISA's field of regulation—ERISA legislation and plan discretion—also exclude state laws from that field. Thus, none opposes respondents' conclusion, establishing § 2807-a(6) free of preemption by § 514(a), because ERISA does not legislate and plans cannot decide the price of inpatient services. Indeed, since five of the seven decisions the petition cites involve state laws that were preempted because they mandated plan benefits,† the decisions illumine the line drawn by respondents' analysis that places those state laws firmly and exclusively within ERISA's field of regulation. See pp. 21-22.

The petition (at 9 ,12, 14, 19) puts aside the text of PHL § 2807-a(6) and the statute's role in NYPHRM when it claims that the state law "relates to" ERISA-covered employee welfare plans under § 514(a), 29 U.S.C.

* *Hewlett-Packard Co.* v. *Barnes, supra.*

** *Alessi* v. *Raybestos-Manhattan, Inc., supra,* and *Shaw* v. *Delta Air Lines, Inc., supra,* are typical of the decisions the petition cites holding state laws that interfere with plan discretion preempted by § 514(a). *Alessi* preempted a state law that eliminated a method of calculating pension benefits which, absent the law, plans could use or not, as they chose. *Delta Air Lines* preempted a state law that mandated pregnancy disability benefits which, absent the law, plans could provide or not, as they chose. The state laws involved in the four other decisions the petition cites were to the same effect, *i.e. Metropolitan Life Insurance Co.* v. *Massachusetts, supra; Stone & Webster Engineering Corp.* v. *Ilsley, supra; Standard Oil of California* v. *Agsalud, supra;* and *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities.*

† *Metropolitan Life Insurance Co.* v. *Massachusetts, supra; Shaw* v. *Delta Air Lines, Inc., supra; Stone & Webster Engineering Corp.* v. *Ilsley, supra; Standard Oil of California* v. *Agsalud, supra;* and *Pervel Industries* v. *Connecticut Commission on Human Rights, supra.*

§ 1144(a), because its price control identity is merely a "[dis]guise" (*id.* at 14, 19) for its true purpose or effect (*id.* at 12, 24 n. 19), regulating the "form" of covered plans. *Id.* at 9 ¶1.* See also Local 338 *amicus curiae* brief at 7, 10-11. According to the petition (at 12), "form," *i.e.* whether benefits are provided through self-insurance or the purchase of insurance, is indirectly determined by § 2807-a (6), because the statute prohibits hospitals from negotiating discount charges with plans, a claimed "dis-incentive" to self-insurance, and grants non-profit health insurers twelve to fifteen percent differentials, *i.e.*, discounts from equal charges, a claimed 'incentive' to purchasing their insurance. *Id.* at 12 & n. 10.** See also local 338 *amicus curiae* brief at 10-11.

On examination, the petition's claim that PHL § 2807-a (6) is preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because of its supposed effect on plan "form," amounts to no more than a restatement of the claim, already shown insufficient, that § 514(a) preempts § 2807-a(6) because the state law may reduce benefits by increasing inpatient services prices. See pp. 21-22, 24-26. As established earlier (pp. 21-23), the ERISA and NYPHRM fields of regulation are determined by the content of affirmative legislation and the discretion to make decisions on given subjects. Cov-

* The only purpose of PHL § 2807-a(6) disclosed by the record is its NYPHRM purpose. With state-established or approved rates, § 2807-a(6) implements the inpatient income needs of hospitals, as determined by their NYPHRM revenue caps, and equitably apportions that cost. See pp. 2-10.

** The supposed prohibition/dis-incentive for self-insurance the petition asserts assumes that there is only one reason or, at least, one economic reasor, *i.e.* negotiation of charges, an ERISA-covered plan would decide to self-insure. However, according to the United Optical plan's own agent, there are at least four other economic reasons for plans to self-insure. See p. 11 n.**. See also p. 4 n.**, showing that differentials for non-profit health insurers are justified, and p. 25 n.** ¶2, showing that the supposed "dis-incentive" for self-insurance the petition (at 12 & n.10) attributes to New York and the supposed incentive for self-insurance it attributes to Massachusetts (*Ibid.*) are not present in fact.

ered plans decide whether to self-insure or not, placing that subject, like the subject of the plan benefits, within ERISA's field of regulation. See ERISA § 3(1), 29 U.S.C. § 1002(1) and p. 10. NYPHRM, through state-established or approved rates and the § 2807-a(6) equal charges requirement, decides the price of inpatient services. NYPHRM does not decide plan "form" any more than it decides plan benefits, *i.e.* it has no regulatory authority over the subject, the *sine qua non* for ERISA preemption of a state law under § 514(a), 29 U.S.C. § 1144(a). See pp. 21-23.* The proof that NYPHRM is without authority over plan "form," either under § 2807-a(6) or any other state law, is that only plans can decide their form, and no state agency can compel them to make particular choices. See pp. 21-23 esp. 23 n.*.

The Local 338 *amicus curiae* brief (at 8-10) adopts the petition's contention that PHL § 2807-a(6) regulates plan "form" and takes it one step further, distancing the statute even more from its actual purpose (see pp. 2-10, 28 n.*), and from preemption under ERISA § 514(a), 29 U.S.C. § 1144(a). According to the *amicus* (at 8-10), § 2807-a(6) has two "hidden agendas," both alleged to subject the statute to preemption under § 514(a). First, the *amicus*, like the petition, claims that § 2807-a(6) forces covered plans to abandon self-insurance and to purchase health insurance. Second, the *amicus* claims that § 2807-a(6) mandates benefits for covered plans because the health insurance policies the plans will have to buy have mandatory minimum coverage required by the New York Insurance Law.

The theory offered by the *amicus* proves too much even if its without record basis and dependence on an uncertain chain of causation are put aside. If, in fact,

* Of course, a state law that "indirectly" regulates plan "form" could be challenged under ERISA § 514(a), 29 U.S.C. § 1144(a). *See Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). However, indirect regulation does not mean inferential regulation. The state law would have to control the subject as *Alessi* demonstrates, since the law there preempted, eliminated one method of calculating pensions. Neither NYPHRM, PHL § 2807-a(6) nor any other state controls, *i.e.* decides, plan "form."

PHL § 2807-a(6) required covered plans to abandon self-insurance, which it does not (see pp. 27-29), the statute would be preempted by ERISA § 514(a), 29 U.S.C. § 1144 (a), at step one of the *amicus'* theory, and step two would not be reached. If § 2807-a(6) were not preempted at step one, as it is not, it would not be preempted at step two because the plans' purchase of the policies would be voluntary action, not the result of state law. Perhaps most critically, if state laws mandating minimum coverage in health insurance policies are subject to preemption under §514(a) when covered plans buy the policies, the New York Insurance Law is in issue, not § 2807-a(6), the only state law the petition (at i, 49a-50a) claims is involved. Conversely, if state laws mandating minimum coverage in health insurance policies that plans buy are not subject to preemption under § 514(a), § 2807-a(6) cannot be subject to preemption either since, on the *amicus'* theory, the statute does no more than allow plans access to policies whose state-regulated terms are free of preemption under § 514(a).

## Conclusion

**For the Foregoing Reasons, the Petition for a Writ of Certiorari Should Be Denied.**

Respectfully submitted,

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